New Jersey Department of Health and Senior Services
Nursing Home Administrators Licensing Board

QUARTERLY PROGRESS REPORT FOR NURSING HOME ADMINISTRATOR IN TRAINING PROGRAM OR ASSISTANT ADMINISTRATOR POSITION

Mailing Address:
PO Box 367
Trenton, NJ 08625-0367

Overnight Services (UPS, FedEx, Airborne):
120 South Stockton Street, Lower Level
Trenton, NJ 08611-1730

INSTRUCTIONS TO APPLICANT: *Complete* ***Section I and forward to Preceptor for review of Section I and completion of Section II.***

INSTRUCTIONS TO PRECEPTOR: Review Section I and complete Section II and forward to the Nursing Home Administrators Licensing Board at either of the two listed addresses.

SECTION I - TO BE COMPLETED BY APPLICANT

Name of Applicant	Social Security Number

Type of Program	Program Start Date	Anticipated Completion Date
☐ Administrator-in-Training ☐ Assistant Administrator	____ / ____ / ____	____ / ____ / ____

Quarterly Report Number	Time Period Covered
☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8	From: _____ To: _____

Hours Completed:

Service Area/Department	This Report	YTD
1. Resident Activities		
2. Administration		
3. Business Office		
4. Dietary		
5. Maintenance		
6. Medical Records		
7. Nursing		
8. Social Services		
9. Environmental (including Housekeeping and Laundry)		
10. Other (Specify):		
_____		
_____		
TOTAL HOURS		

Describe the training you received during this report period (departments in which you worked, time spent in each department, summary of learning experiences, brief analysis of any problems observed or insights gained, special projects, points of interest, etc.) (Attach additional sheets if necessary.)

I certify that the statements made by me are true and correct to the best of my knowledge and belief.

Signature of Applicant	Date

QUARTERLY PROGRESS REPORT FOR
NURSING HOME ADMINISTRATOR IN TRAINING PROGRAM
OR ASSISTANT ADMINISTRATOR POSITION
(Continued)

Name of Applicant	Social Security Number

SECTION II - TO BE COMPLETED BY PRECEPTOR

Name of Preceptor	NHA License No.	No. of Years Licensed as NHA

Name of Licensed Long Term Care Facility Training Site

Street Address

City, State, Zip	Telephone Number

Comment on the knowledge, skills and abilities acquired during this report period, accuracy and completeness of monthly intern logs, problems encountered, and whether internship is proceeding satisfactorily. (Attach additional sheets if necessary.)

CERTIFICATION

I have reviewed the statements made by the applicant in Section I for accuracy. I certify that the statements made by me in Section II are true and correct to the best of my knowledge and belief.

Signature of Preceptor	Date

Distribution: Original - NJDHSS
Copy - Preceptor
Copy - Applicant